PRAIRIE VIEW A&M UNIVERSITY

WAIVER, INDEMNIFICATION, AND MEDICAL TREATMENT AUTHORIZATION FORM

1. EXCULPATORY CLAUSE. In consideration for receiving permission to participate in any and all activities of _____ ("activity"), which is sponsored by _____ Prairie View A&M University, a member of The Texas A&M University System, I hereby release, waive, covenant not to sue, and agree to hold harmless for any and all purposes sponsor, The Texas A&M University System, the Board of Regents for The Texas A&M University System, and their members, officers, agents, volunteers, or employees ("RELEASEES" or "INDEMNITEES") from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while participating in this activity, while traveling to and from the activity, or while on the premises owned, leased, or controlled by RELEASEES, ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELEASEES.*** I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

2. INDEMNITY CLAUSE. I am fully aware that there are inherent risks to myself and others involved with this activity, including but not limited to _____, and I choose to voluntarily participate in this activity with full knowledge that the activity may be hazardous to me and my property, and to the person and property of others. I acknowledge there may be physically strenuous activities. I know of no medical reason why I should not participate. ***I agree to indemnify and hold harmless INDEMNITEES*** from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, which may occur to myself, other participants, and third-persons as a result of my participation and conduct in this activity, ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of INDEMNITEES.***

3. NO INSURANCE. I understand that RELEASEES do not maintain any insurance policy covering any circumstance arising from my participation in this activity or any event related to that participation. As such, I am aware that I should review my personal insurance coverage. Sponsor does not carry general liability insurance to cover claims arising from this activity so it seeks a waiver of claims as additional consideration for the right to participate so sponsor, a governmental unit of the State of Texas, can (a) provide the activity at the lowest possible cost to participants; and (b) provide access to a greater number of participants by expending limited resources on program materials rather than on liability insurance.

4. BINDS HEIRS. It is my express intent that this agreement shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be governed by the laws of the State of Texas.

5. MEDICAL AUTHORIZATION, INDEMNITY FOR MEDICAL EXPENSES, and WAIVER. I understand RELEASEES cannot be expected to control all of the risks associated with this activity and RELEASEES may need to respond to accidents and potential emergency situations. Therefore, I hereby give my consent for any medical treatment that may be required, as determined by a medical professional at the medical facility, during my participation in this activity with the understanding that the cost of any such treatment will be my responsibility. I agree to indemnify and hold harmless INDEMNITEES for any costs incurred to treat me, even if an INDEMNITEE has signed hospital documentation promising to pay for the treatment due to my inability to sign the documentation. I further agree to release, waive, covenant not to sue, and agree to hold harmless for any and all purposes, RELEASEES from any and all liabilities, claims, demands, injuries (including death), or damages, including court costs and attorney's fees and expenses, that may be sustained by me while receiving medical care or in deciding to seek medical care, including while traveling to and from a medical care facility, ***including injuries sustained as a result of the sole, joint, or concurrent negligence, negligence per se, statutory fault, or strict liability of RELEASEES.*** I understand this waiver does not apply to injuries caused by intentional or grossly negligent conduct.

6. VOLUNTARY SIGNATURE. In signing this agreement I acknowledge and represent that I have read it, understand it, and sign it voluntarily as my own free act and deed; sponsor has not made and I have not relied on any oral representations, statements, or inducements apart from the terms contained in this agreement. I execute this document for full, adequate and complete consideration fully intending to be bound by the same, now and in the future. **For students engaging in extracurricular activities:** I understand I can choose not to sign this document and free myself from its terms and the associated risks of the activity by simply not participating in the activity and choosing some other activity available to me that has a lower level of risk to me. I further understand this is a voluntary, extracurricular activity; therefore it is not required for me to obtain college credits and not participating in this activity will in no way hinder my ability to obtain a degree from the university. **For students going on fieldtrips or other class-related activities:** I understand participation in this class/fieldtrip/activity is not mandatory and I will not be penalized for failing to participate in this activity because an alternative activity exists for which I can receive like credit. While I understand alternative activities are available to me that do not have the risks associated with this activity I still desire to voluntarily engage in this activity.

SIGNING THIS DOCUMENT INVOLVES THE WAIVER OF VALUABLE LEGAL RIGHTS. CONSULT YOUR ATTORNEY BEFORE SIGNING THIS DOCUMENT.

SIGNED this _____ day of _____, 20_____.

Participant Signature: _____

Printed Name: _____

Participant's Date of Birth: _____

Parent or Legal Guardian Signature: _____
(If Participant is under 18 years old)

Parent or Legal Guardian Printed Name: _____
(If Participant is under 18 years old)

INSTRUCTIONS: (1) The document should be printed in a font size no smaller than 10-point type. This is 10-point type. This is 12-point type. (2) The formatting/font style (***bolded, underlined, and italicized***) in paragraph nos. 1, 2, 5 & 6 should not be altered.

TAMUS-OGC-Approved 5/7/2015

PRAIRIE VIEW A&M UNIVERSITY

Prairie View A&M University Youth Program Medical Treatment Authorization Form

This form must be completed and returned before youth camp/program/event enrollment dates in order for youth to be permitted to participate in any program activities.

Personal Information

Child's Last Name_____ First Name_____ Birthdate_____ ❑ M ❑ F

Specify program your child will be attending _____

Address_____ City_____ State_____ Zip _____

Home Phone_____ E-mail Address _____

Parent/Guardian #1_____ Parent/Guardian #2_____

Daytime Phone_____ Daytime Phone _____

Place of employment_____ Place of employment _____

Health Insurance Carrier_____ Policy Number_____

Plan Number_____ Is physician authorization needed? ❑ Yes ❑ No

Name of Family Physician_____ Phone _____

☐ ***(Please attach a copy of medical insurance card to this form)***

In case of emergency, please notify

If neither parent nor guardian is available in an emergency, please contact:

1. _____ Phone _____

2. _____ Phone _____

☐ ***(Please attach a copy of current immunization records to this form)***

Health History [Please check and provide approximate dates if the youth suffered any conditions listed below]

	Date		Date		Date	List Major Illness:
❑ Asthma		❑ Heart Disease		❑ Skin Disorder		
❑ Anemia		❑ Heart Murmur		❑ Seizures		
❑ Arthritic Condition		❑ Hypertension		❑ Sickle Cell Anemia		
❑ Cancer/Leukemia		❑ Kidney Disease		❑ STD		
❑ Chicken Pox		❑ Lupus		❑ Thrombophlebitis (Blood Clot in vein)		
❑ Diabetes		❑ Mental Illness		❑ Liver Disease		
❑ Fainting		❑ Migraine Headaches				
❑ Head Concussion with loss of consciousness		❑ Multiple Sclerosis		❑ Other		

Allergies:	Medications:	Fractures & Dislocations:	Surgery:
		Type:	Type:
		Date:	Date:
		Type:	Type:
		Date:	Date:
		Type:	Type:
		Date:	Date:

Is there anything else in youth's health history that the program staff should know? _____

Are there any activities from which the youth should be restricted? _____

Please list any special services your child may require _____

Does the youth have any special dietary restrictions? ❑ NO ❑ Yes If YES, explain: _____

Does the youth wear any medical appliances (glasses, contact lenses, orthodonture, etc.)? ❑ NO ❑ Yes If YES, explain: _

PRAIRIE VIEW A&M UNIVERSITY

Prairie View A&M University Youth Program Medical Treatment Authorization Page 2

Youth's Last Name_____First Name_____Birthdate_____❑ M ❑ F

The parent(s)/legal guardian(s) of Youth Program participants are required to disclose their intention to bring medications to the Program, especially to treat potentially life-threatening conditions (i.e. inhalers, EPI-pens, insulin injections). Upon arrival to the Program, parent(s)/legal guardian(s) should plan to meet with a member of the Youth Program staff at registration to review medication issues for a Youth Program participant and complete additional required paperwork if not completed prior to arrival. For identification purposes, a current picture of the child is to be provided upon registration.

All medications (prescription and over-the-counter) must be stored in the original product packaging and clearly labeled with the participant's name. Prescription medication(s) must also include a label with the medication's name and dosage instructions, as well as the prescribing physician's name and telephone number.

All medications will be kept in a securely locked cabinet used exclusively for storage of medications. Medications that require refrigeration will be stored in a refrigerator that is secured and designated for medications **ONLY**. Access to all medications will be limited to approved personnel. The need for emergency medication may require that a Youth Program participant carry the medication on his/her person or that it be easily accessed (i.e. inhalers, EPI-pens, insulin injections). PVAMU Youth Program staff will **NOT** purchase medications of any type (prescription or over-the-counter) for Youth Program participants of any age.

If a Program has professional medical staff on-site, then the medical staff may administer over the counter medications (e.g., ibuprofen or Tylenol) supplied by the parent(s)/guardian(s) per package instructions. Medical staff may monitor the self-administration of medications, if necessary, upon written consent of the parent(s) and/or legal guardian(s) and/or physician orders.

If there are no medical staff on-site, PVAMU Youth Program staff *will not* dispense medications, but may monitor the self-administration of certain medications if necessary, ***ONLY*** upon written consent of the parent(s)/legal guardian(s) and /or physician's orders.

It is NOT permissible for a participant to share any medications with any other participants.

It is the responsibility of the parent(s)/legal guardian(s) to be sure that the participant's medications brought to the Youth Program are not left behind at the end of the Program. Failure to do so will result in the medications being destroyed within three working days after the participant's last day at the Program. Absolutely no medications will be returned via mail regardless of circumstance.

CONCENT FOR MEDICAL TREATMENT:

I hereby authorize the clinical staff of PVAMU Owens-Franklin Health Center or other licensed practitioner of the healing arts, acting within the scope of his or her practice under State law, to provide medical care that includes routine diagnostic procedures (e.g., x-rays, blood and urine tests) and medical treatment as necessary to my minor daughter/ son/dependent. I understand that the consent and authorization herein granted does not include major surgical procedures and are valid only during the Youth Program/event.

In the event that an illness or injury would require more extensive evaluation, I understand that every reasonable attempt will be made to contact me. However, in the event of an emergency and if I cannot be reached, I give my consent for physicians and staff at PVAMU Owens-Franklin Health Center or other licensed practitioners of the healing arts to perform any necessary emergency treatment. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. I understand that PVAMU Owens-Franklin Health Center does charge for services and that it is my responsibility to pay the bill if a claim can't be submitted by the PVAMU Owens-Franklin Health Center to my private insurance. As applicable, I may be responsible to submit any claims to my health insurance company for reimbursement. I authorize Prairie View A&M University to receive medical/billing information and submit it to the University's insurance carrier.

I understand that, that Prairie View A&M University does not provide medical insurance to cover emergency care or medical treatment of my child. It is recommended that you have appropriate medical coverage for your child.

I understand that Prairie View A&M University recommends that medication(s) be given at home before and/or after the Youth Program. However, when this is not possible, and medications will be brought to Youth Program camp, I agree to the provisions outlined above relating to the management of medications.

HIPAA

Prairie View A&M University is required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.
https://www.pvamu.edu/auxiliaryservices/health-services/hipaa/

_____ _____

Parent/ Legal Guardian Name (please print) Parent/ Legal Guardian Signature

Date: _____

Revised February 17, 2017

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Please complete this form only if your youth will require medication(s) during the program.

If at all possible, medication should be administered at home. Medications will be allowed at the Youth Program only when failure to take such medicine would jeopardize the health of a child and he/she would not be able to attend the Youth Program if the medicine were not made available.

Personal Information

Child's Last Name_____ First Name_____ Birthdate_____ ❑ M ❑ F

Specify program your child will be attending _____

Address_____ City_____ State_____ Zip _____

Home Phone_____ E-mail Address _____

Parent/Guardian #1_____ Parent/Guardian #2_____

Daytime Phone_____ Daytime Phone _____

Health Insurance Carrier_____ Policy Number_____

Plan Number_____ Is physician authorization needed? ❑ Yes ❑ No

Name of Family Physician_____ Phone _____

☐ ***(Please attach a copy of medical insurance card to this form)***

In case of emergency, please notify

If neither parent nor guardian is available in an emergency, please contact:

Name:_____ Phone:_____

Relationship:_____

Name:_____ Phone:_____

Relationship:_____

If there are any changes prior to arriving at the program, please provide an updated list upon arrival.

Medication	*Reason(s) for Medication*	*Daily Dosage/Time(s) Taken*
1		
2		
3		
4		
5		
6		
7		